ACTIVE DUTY U.S. MILITARY

ATTENDING DENTIST'S STATEMENT

Check ( ) Dentist's pre-treatment estimate

One: ( ) Dentist's statement of actual services

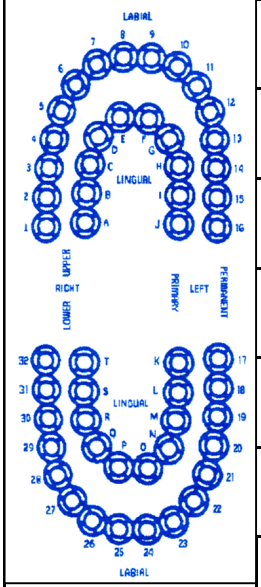
PATIENT SECTION

1. Patient name First Middle Last	2. Sex	3. Age	4. COUNTRY (where treatment provided) ___ Permanent party ___ TDY/LV/Deployed
5. Social security number	6. Branch of Service Rank		
7. Patient mailing address (APO/FPO or street, city, country, postal mailing code)	8. Date assigned remote location:		
	9. DEROS / PRD / Rotation:		
	10. Telephone number (include country, city, and/or area code)		
11. I have reviewed the following treatment plan. I authorize release of any information relating to this claim. Signature of Patient ____ Date ____	12. Email address:		

DENTIST SECTION

13. Dentist name	14. Dental Office Point of Contact:			
15. Office address - city, country, postal mailing code	16. Is treatment result of occupational injury or auto accident	No	Yes	If yes, enter brief description and date
	17. If prosthesis, is this initial placement?			If no, reason for replacement
18. Dentist phone no. (including country, city, area code)	19. Dentist fax no.			
20. Dentist email address	21. Remarks:			

Indicate tooth/ teeth no.(s) for which services were provided.



22. Examination and Treatment Plan

TOOTH NO. U.S.	TOOTH NO. INT'L	SURFACE	DESCRIPTION of SERVICES (including DIAGNOSIS, TREATMENT, MATERIALS)	DATE of SERVICE Month	Day	Year	FEE CHARGED
			Diagnosis: Treatment:				
			Diagnosis: Treatment:				
			Diagnosis: Treatment:				
			Diagnosis: Treatment:				
			Diagnosis: Treatment:				

28. Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and or federal law and may also be subject to civil penalties. I hereby certify that the procedures as indicated by date have been completed.

DENTIST SIGNATURE ____ DATE ____

29. INDICATE CURRENCY: ( ) USD ( ) LOCAL

30. ATTACHMENTS
___ Treatment Plan
___ Xrays
___ Photos
___ Other

TOTAL FEE

AMT PAID

BALANCE

WPJ Aug/ 03

THIS FORM IS FOR ACTIVE DUTY MILITARY ONLY